APPOINTMENT DATE:	APPOINTMENT TIME:	Today's DATE:	



Form is ONLY for individuals who are current Medicare recipients or within 3 months. Updated 10/09/2024 **ALL SECTIONS OF THIS FORM MUST BE COMPLETED.**

	Telephone:		
NAME	Alternate Telephone:		
MEDICARE CLAIM NUMBER	Email:		
	Spouse's Name:		
ENTITLED TO EFFECTIVE DATE HOSPITAL (PART A)	Spouse's Date of Birth:		
MEDICAL (PART B)			
DDRESS:			
ITY: STATE: :	ZIP: COUNTY:		
ACE: Date of Birth:			
PRIMARY PHYSICIAN:	Your gross monthly income:		
PREFERRED PHARMACY:	Your spouse's gross monthly income:		
PART D PROVIDER (PDP):	Total HOUSEHOLD INCOME:		
HEALTH INSURANCE PROVIDER: Medicaid Tricare for Life	MEDICARE.GOV ID:		
State Retiree Insurance Medigap	PASSWORD:		
Do you use Baptist Hospitals or physicians?	SECRET QUESTION/ANSWER:		
MEDICARE SAVINGS PLAN/EXTRA HELP	INCOME LIMITS FOR MSP/LIS		
Does the state of ALABAMA pay your Medicare Part B Premium (MSP)?	QMB (Single \$1275/Married \$1724) AMA		
YES NO	SLMB (Single \$1526/Married \$2064) AMA		
	QI-1 (Single \$1715/Married \$2320) AMA		
YES NO	LIS/EXTRA HELP (Single \$1825/Married \$2555) SSA		
*_*_*_*_*_*_*-*-*-*-*TURN PAGE	OVER TO LIST MEDICATIONS*-*-*-*-*-*-*-*-*		
SHIP COUNSE	ELOR USE ONLY		
SCREENER NAME	STAFF VOLUNTEER		
COMPLETED SUBSIDY APPLICATION? YES NO	_		
COMPLETED COMPARISON (DATE) (TIME SE	PENT) IN PERSON		
ENROLLED IN A PLAN? (DATE) (PLAN)			

\cup	The client does not take any prescription medications.						
	The client did not have his/her medication list at the time of the intake; will provide list at a later time.						
	Do NOT include Over the Counter Medications.						
Name o	f MEDICATION	Generic Y/N	Dosage/Frequency (ex. 40 mg/day)	Day Supply (30, 60, 90)			

Return form to:

CENTRAL ALABAMA AGING CONSORTIUM

400 COTTON GIN ROAD, MONTGOMERY, AL 36117

PHONE: 334-240-4680 or FAX: 334-240-4681 or EMAIL: caac.adrc@caac-al.org





